coagula, and, if the cornea be in good position, is closed immediately. If the cornea be sunken, Dr. Jacobson waits until it is elevated by freshly secreted aqueous humour (that is, from five minutes to half an hour) before he applies the Arlt's compress, which, both by Dr. Mooren and himself, is considered an essential part of the treatment.

"During the whole of the operation, the effect of chloroform is maintained in such a degree as to render the ocular muscles absolutely passive; and the inhalation is therefore renewed from time to time as may be needed.

"Dr. Jacobson devotes to the after treatment of his cases a degree of care and attention that must contribute very largely to his success. Each patient, for twenty-four hours after the operation, receives the undivided attention of a nurse. The earliest symptoms of inflammation are met by iced poultices, changed every few minutes, and by continuous leeching where the symptoms are severe, and the patient's strength will permit. Four leeches are applied in front of the ear, and replaced by others as they fall, until no less than from forty to eighty have been used in a single case. Dr. Mooren's method does not seem to entail much liability to inflammation, and he speaks as if little or no treatment had been required by his patients.

"Dr. Mooren asserts that he has operated by his method in sixty cases with only two failures, and Dr. Jacobson states that he has operated by his method in one hundred cases with only two failures."

This is certainly remarkable success, but it remains to be seen whether these methods will prove equally successful in the hands of others. Until this is ascertained, the objections to these methods of operating are so strong that we cannot regard them with favour; but after all their value must be determined by the results obtained, and not entirely by reasoning, however plausible.

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37. *Operation of Abscission in Staphyloma.*—Mr. Critchett describes (*The Royal London Ophthalmic Hospital Reports*, No. 5, 1863) a mode of operating for staphyloma that he has adopted during the last two years in several cases, which seems to him to possess some advantages over the various plans hitherto recommended.

"It will be generally admitted," he says, "that in all cases of complete staphyloma, some operative proceeding is called for. The deformity is usually considerable, and is liable to increase; the part is in a morbid condition, often inflamed and irritable, and exerting an unfavourable influence upon the other eye. Whether it remain in a quiet state, or pass through a series of changes, it becomes desirable to operate. We may now consider what are the conditions that we wish to bring about by the operation.

"The object we have in view is to reduce the staphyloma to a firm elastic bulb, that shall be fully influenced by the various muscles, and shall be about a third less in size, or at any rate, in its antero-posterior measurement, than the normal eye, this condition being the most favourable for the employment of an artificial eye. Various methods have been employed with a view to obtain this result, that which has been most commonly employed up to the present time both in this country and on the Continent, has been to cut away the anterior part of the staphyloma with an ordinary Beer's knife, so as to open into the vitreous chamber. Some slight modifications have been introduced by various operators, some removing only a small portion, others taking away the anterior third, or even half of the staphyloma. Some have introduced a needle previously, so as to allow some of the contents of the globe to escape previous to abscission. Those who have had an opportunity of extensively testing this method of proceeding, have become aware of several serious inconveniences. It not unfrequently happens, that a gush of vitreous humour follows the removal of the anterior supports, and subsequently the enlarged and diseased vessels give way, and continue to bleed for several hours, distending the surrounding parts, causing considerable pain, and ultimately suppuration. This untoward result may follow immediately upon the operation, or a few hours or even days after, or in cases where hemorrhage does not occur, suppuration may occur attended with considerable reaction, and constitutional disturbance. Under either of these contingencies, the globe is apt to shrivel up into a small compass, with very slight movement, and imperfect adaptation for an artificial eye. This shrunken globe occasionally becomes hard and painful, and irritates the companion eye. In other cases where no hemorrhage occurs, and no suppuration follows, the sclerotic opening remains in a patent state, with the vitreous humour or the lens presented. Repair is, under these circumstances, difficult, tedious, and uncertain. The membrane that is formed is not unfrequently elastic, and by yielding to the pressure within, bulges, and constitutes a fresh staphyloma, or forms an unstable and irritable basis whereon to rest an artificial eye. Such are the objections to the methods of operating ordinarily employed for the reduction of a staphyloma, and they lead us in the next place to the consideration of the results we are desirous of obtaining, of the accidents we wish to avoid, and the method proposed for their avoidance. In reducing a staphyloma, the aim and object is to form a dense, fibrous, elastic, movable bulb, filled with fluid, flattened upon its anterior surface, and of such a size as admits the ready adjustment of an artificial eye, and its free movement. In carrying out this object, it is important to mark the size and form of the piece to be removed, to allow of some slight escape of the contents of the eye, so as to avoid a sudden gush, to keep up some support during the operation, and subsequently to place the parts in a favourable condition for supporting the vessels, keeping up pressure, and uniting by the first intention. I will now endeavour to describe the method by which these various objects are intended to be carried out. The patient being placed under the influence of chloroform, the staphyloma is freely exposed by means of a wire speculum, a series of four or five rather small needles, with a semi-circular curve, are passed through the mass about equi-distant from each other, and at such points as the lines of incisions are intended to traverse. These needles are left in this position with both extremities protruding, to an equal extent, from the staphyloma. The advantages gained by this part of the proceeding are: 1st, that a small quantity of the fluid parts of the distended globe escapes, thus diminishing pressure, and preventing a sudden gush of the contents when the anterior part is removed. 2dly, that the points of emergence indicate the lines of incision. 3dly, that the presence of the needles prevents, or rather restrains, to some extent, the escape of the lens and vitreous humour, after the anterior part of the staphyloma has been removed. The next stage of the proceeding is to remove the anterior part of the staphyloma. This requires some judgment and modification in size and form, in accordance with the extent of the enlargement, so as to leave a convenient bulb. My usual plan is to make an opening in the sclerotic, about two lines in extent, just anterior to the tendinous insertion of the external rectus muscle with a Beer's knife. Into this opening I insert a pair of small probe-pointed scissors, and cut out an elliptical piece, just within the points where the needles have entered and emerged. The needles, armed with fine black silk, are then drawn through each in its turn, and the sutures are carefully tied so as to approximate as closely as possible the divided edges of the sclerotic and conjunctiva. The operation is now finished; the speculum may be removed so as to allow the lids to close, and wet lint may be applied to keep the parts cool. In a large majority of cases, union of the divided edges takes place by the first intention. The operation has been performed by myself and by my colleagues at Moorfields Hospital, in about thirty cases, and suppuration only occurred in four cases. I generally leave the sutures in for some weeks. Sometimes they come away spontaneously, and when that is not the case, they may readily be removed after all irritation has passed away, and after firm union has taken place. If the case be examined three or four months after the operation, a movable bulb is seen with a flattened anterior surface, traversed by a transverse white line of cicatrix, and having rather a prominent external angle. Upon this an artificial eye can be readily adapted, which moves to a greater extent than I have observed previous to the adoption of my present plan.

"In reviewing the various stages of this operation, I think it will be admitted that it accomplishes the objects for which it is undertaken in a safe and rapid manner, and avoids to a great extent the inconveniences that attend the methods usually adopted. Hemorrhage and suppuration are prevented, the size of the bulb is regulated by the union of its edges by the first intention, and a firm, elastic, fibrous case is formed, possessed of extensive mobility, and admirably adapted to bear an artificial eye."